DASIS STATE DATA ADVISORY GROUP MEETING

March 22–23, 2005
Atlanta, Georgia

SUMMARY of DASIS STATE DATA ADVISORY GROUP MEETING

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This was the 19th regional meeting to be held with State DASIS representatives. It included representatives from the District of Columbia, Florida, Georgia, North Carolina, South Carolina, and Virginia, along with staff from the SAMHSA Office of Applied Studies (OAS), Mathematica Policy Research (MPR), and Synectics for Management Decisions, Inc. (Synectics).

The DASIS regional meetings are held to provide an opportunity for face-to-face discussions among State DASIS representatives, the staff of OAS, and the DASIS contractors, Synectics and MPR. The meeting agenda, while planned beforehand to include items of mutual interest, is flexible to maximize the opportunity for discussing issues of particular importance to the State representatives in attendance. Through discussion and brief presentations, States are informed about recent OAS activities and are given an opportunity to share with OAS and each other their concerns and solutions to common problems in data collection and management of information.

Opening

Charlene Lewis, acting Director of the Office of Applied Studies (OAS), gave opening remarks. She emphasized the importance of these meetings to OAS and the value SAMHSA receives from the State presentations and the interchange of ideas during the meeting with the State representatives. Charlene reminded the group that comments and suggestions at these meetings often result in substantive changes in the DASIS programs. She mentioned that at this meeting OAS would be requesting States' input for the 2006 N-SSATS Questionnaire.

National Survey of Substance Abuse Treatment Services (N-SSATS)

Barbara Rogers, MPR, reported on results of the 2004 N-SSATS.

The overall response was a remarkable 97.2 percent for State-approved facilities. Among the States attending the meeting, the response rates ranged from 95.1 percent to 97.8 percent.

Of the facilities sent questionnaires, 8.6 percent were closed or no longer provided substance abuse treatment. Of the eligible facilities, slightly under 50 percent completed the questionnaire by mail, and just over 30 percent responded on the web. After two mail questionnaires were sent to facilities, survey non-respondents were called and asked to complete the survey over the telephone. In 2004, this accounted for 20.8 percent of the responses. The average percentage by mode for the States attending the meeting was slightly higher than the overall national distribution.

Although 91.5 percent of the facilities reported having Internet access, only one-third reported using the web. Charlene remarked that these numbers do not look promising and asked the States for ideas that would help facilities to move from mail responses to responding by the web.

States reported that there is usually a learning curve, but as more States move toward web reporting of clients they probably will move to web reporting for N-SSATS. On the positive side, over 90 percent of the people who signed on to the web completed on the web.

Looking at responses by week, almost one half of the responses were received by week 8. It took another 22 weeks for the remaining responses. During the data collection period there were several mailings to improve response. It appears that they all achieved the desired effect. Within a week of the reminder mailing and the second questionnaire mailing responses increased.

The 2005 questionnaire will be mailed out on March 31, and the web questionnaire will be available online. Once again, the cooperation from all the States was excellent. Endorsement letters were provided by all States.

On April 19th, MPR will send a reminder letter, and at the end of May an entire questionnaire package will be sent to non-respondents.

In June, MPR will contact the State N-SSATS representatives to see if they want to assist in contacting non-respondents. Telephone follow-up will begin on June 24th, and data collection will end on October 3rd.

2006 Questionnaire

Every three years SAMHSA has to request and receive clearance from OMB for the N-SSATS questionnaire. So, every three years it is possible to make significant changes in the questionnaire and add new questions.

Below is a brief summary of the new and revised questions proposed for the 2006 questionnaire as presented by Geri Mooney, MPR, and some of the comments from those in attendance.

Proposed Question Revisions for 2006

1. Currently, the questionnaire asks if a facility offers inpatient detoxification and/or treatment and residential detoxification and/or treatment. In 2006, it is proposed to join these two questions and ask which of the following services a facility offers:

- Medically managed or monitored inpatient detoxification (ASAM levels III.7-D and IV-D);
- Clinically managed residential detoxification or "social detoxification" (ASAM level III.2-D);
- Medically monitored intensive inpatient treatment (ASAM level III.7);
- Clinically managed, medium or high intensity residential treatment, 30 days or less (ASAM levels III.3 and III.5); and
- Clinically managed, low intensity residential treatment, more than 30 days (ASAM level III.1.)

  South Carolina, North Carolina, and Florida thought these were good changes and that the majority of facilities would understand them. A suggestion was made to include definitions for medically monitored and to add ASAM level IV, medically managed intensive inpatient services, as a category.

Charlene Lewis commented that a group assembled to help assist SAMHSA with the national outcome measures suggested that when there is a new mode of care it should be included in both N-SSATS and TEDS in order to monitor outcomes of new modes. This means that these types of changes may be more common in the future than in the past.

Florida raised the issue that inclusion of the ASAM levels in the questionnaire may be an infringement of ASAM copyright. Charlene responded that OAS would check on that.

Florida was concerned about the cost of changes to the TEDS data system, particularly for private vendors, and the need for sufficient lead time to make the changes. Florida has a mixture of State and private vendors: the State needs time to disseminate the changes to the providers, and the providers need lead time to get changes made by their vendors.

Barbara Rogers of MPR remarked that there was a similar question later in the questionnaire that requires facilities to report their clients in categories. No one objected to this question.

2. It is proposed to revise the outpatient services question for 2006 by adding the ASAM definitions and levels of care. The categories proposed for 2006 are:

- Ambulatory (outpatient) detoxification (ASAM levels I-D and II-D);
- Partial hospitalization/day treatment, 20 or more hours per week (ASAM level II.5);
- Intensive outpatient treatment, 9–19 hours per week (ASAM level II.1);
- Non-intensive outpatient treatment, less than 9 hours per week (ASAM level I); and
- Opioid maintenance therapy.

Barbara Rogers mentioned that when, during a pretest for a previous N-SSATS, the word "ambulatory" was added to the outpatient detox question, it was discovered that many respondents did not know what "ambulatory" meant.

North Carolina commented that it would be a good idea to keep the categories consistent in terms of language and hours per week.

Proposed New Questions for 2006

1. For the first time in N-SSATS, OAS is proposing to ask what types of detoxification services facilities offer and whether a facility routinely uses methadone, buprenorphine, or other substitution medications during detoxification. The suggested question on detoxification services is: "Does this facility detoxify clients from…" and the potential response categories are alcohol, opiates, sedatives, and other.

There was no negative response to the question. Charlene Lewis suggested that maybe cocaine and stimulants should be added to the list of drugs. North Carolina commented that the State was seeing a movement toward prescription drugs. The problem with that, as Florida commented, is that there are so many: Florida lists 67. One possibility is to be consistent with the TEDS list. However, the TEDS list is also long.

2. Another newly proposed question will ask facilities which treatment approach best describes the approach used at this facility. The treatment approaches listed are: 12-step program, bio-psychosocial, cognitive behavioral, eclectic, and other. Facilities would be asked to mark one only.

States were asked whether these would be the approaches they would list and how many OAS can expect a facility to use.

Among the comments was that there is no common terminology. While something like the 12-step program is one that most people will recognize, many of the others will not be as well recognized.

3. It is proposed to ask facilities to report the percentage of clients that receive both individual and group counseling, individual counseling only, and group counseling only.

Florida commented that most large agencies will probably say 100 percent of clients receive both individual and group counseling.

4. The next proposed question is to ask facilities how often they use each of a set of common clinical practices. The frequency scale includes never, rarely, sometimes, and often.

It was suggested that the list should be put in the context of evidence-based practices to improve the understanding of the question. Another suggestion was to add alcohol to the item on drug abuse counseling. Some attendees believed that the category "supportive counseling" is too vague.

5. Another proposed question will ask facilities to report the quality assurance (QA) practices that are part of their <u>regular</u> procedures.

Attendees discussed the use of the word "regular" and commented that it might have different meanings for the various practices listed. For instance, Florida mentioned that if the facility is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JACHO), the requirement for client outcome follow-up studies is 3 months post discharge.

Another comment was in regard to "periodic utilization reviews," which attendees felt had to be more specific.

Another item on the list is, "Weekly staff meetings where cases are reviewed." Several States said that it is important to add the words "clinical supervision" to the question.

6. Over the years, N-SSATS has asked facilities what type of payments they accept. In 2006, it is proposed to add a new category about accepting Access to Recovery vouchers. The concern is whether or not facilities will know if someone is paying with money from the Access to Recovery Program.

In Florida, the ATR grant requires that each client be offered options of where to receive services, and one option must be a faith-based provider. Clients are given a voucher and the value of the voucher, and they may have a voucher to go to multiple providers. They have a choice and have to acknowledge that they have a choice. To provide treatment, providers must be licensed through the department. There is a State standard when it comes to treatment.

Fourteen (14) States and one tribal organization have received ATR grants.

7. Another new question proposed for 2006 is: "Approximately what percent of the substance abuse treatment clients enrolled at this facility on March 31, 2006, had co-occurring substance abuse and mental health disorders?" Facilities will be asked to record a percent.

No one indicated that this question would be a problem for facilities.

8. Each year, the N-SSATS questionnaire includes a list of services, and respondents are asked to mark all the services offered at their facility. In 2006, it is proposed to add the following services: outreach, brief intervention, interim services, social skills development, mentoring/peer support, and substance abuse education.

No one objected to these additions.

Inventory of Substance Abuse Treatment Services (I-SATS)

Alicia McCoy, Synectics, reported on I-SATS and the importance of States keeping I-SATS current.

I-SATS began as a database that contained State-approved treatment, prevention, and other non-treatment facilities, but it has evolved to contain five categories of facilities:

1. State-approved facilities;
2. Non-State-approved facilities that the State designates as appropriate for inclusion in the National Directory and Facility Locator;
3. Opioid Treatment Programs (OTPs) that are certified by CSAT;
4. Non-State-approved facilities; and
5. Federally-owned or -operated facilities.

Synectics receives information about new facilities and updates for facilities on I-SATS through a number of different sources, although the primary sources of information are the State substance abuse agencies. Most States provide information about new facilities and facility updates on a regular basis through I-SATS On-Line. Over the past several years, other important sources of facility information have emerged. With the growth and recognition of the Facility Locator, many facilities wish to be included and contact Synectics directly through e-mail and telephone. In addition, periodically Synectics performs an "augmentation" to identify and add new facilities to I-SATS. This process generally is done by searching the directories of businesses and the American Hospital Association for treatment facilities not on I-SATS.

Another important source of new or updated facility information is the annual N-SSATS. During the data collection period, Synectics receives information about new facilities from other facilities in the survey. Generally, facilities that are part of a "network" report other facilities in the network that did not receive the survey questionnaire. The front cover of the N-SSATS questionnaire also provides facilities an opportunity to update their own information by submitting changes to name, address, and other data.

When Synectics receives a request to be listed in I-SATS directly from a facility, staff first searches I-SATS to verify that the facility is not currently in I-SATS. If the facility is not, the facility is added as a non-State-approved facility, and the facility information is e-mailed to DASIS State representatives to determine if the facility is State-approved. States usually receive these e-mails from Tara Davis, another member of the Synectics I-SATS staff. When Tara receives a response from a State regarding whether or not the facility is State-approved, she makes a notation in I-SATS to record that the facility has been reviewed.

Facilities that are added to I-SATS and approved by the State after the file of facilities has been "frozen" for the N-SSATS receive a Mini-N-SSATS interview. Mini-N-SSATS interviews are conducted by MPR. If a facility responds, it is added to the on-line Facility Locator during the monthly updates of the Locator. Facilities that have closed or had address changes are also removed or updated during the monthly updating process.

Because facility information is available to and used by the public through the Facility Locator and the National Directory, it is very important that I-SATS be kept current, complete, and accurate. I-SATS On-Line and I-SATS Quick Retrieval Service (IQRS) are Internet tools that States can use to maintain their I-SATS listings. IQRS allows States to see an up-to-the-minute record of what is currently listed in I-SATS, including all State-approved, non-State-approved, active, and inactive facilities. When additions or changes are needed, I-SATS On-Line provides an easy method for adding new facilities to I-SATS and changing information for facilities already on I-SATS. When additions and changes are submitted by a State using I-SATS On-Line, the information goes into a staging table for review by I-SATS staff before the I-SATS database is updated. If there is any discrepancy between the information submitted by the State and information obtained from other sources by Synectics, Tara sends an e-mail to the State to reconcile this information. Only after any discrepancy is resolved to the satisfaction of the State is the change made to the I-SATS database.

National Provider Identifier

Deborah Trunzo, OAS, discussed the soon-to-be-required national identifier.

By regulation, all health care providers under HIPAA must apply for a national identifier that must be used with all HIPAA transactions. This identifier will include the facility's name, mailing address, telephone number, and will classify the "facility" as an individual provider, clinic, or facility. Another requirement is that the information be updated every 30 days. The goal is for each "facility" to have a lifelong ID number. This will have an impact on how SAMHSA and the States do business in DASIS, but it is still unclear how the identifier will operate and how it will actually impact on I-SATS and TEDS. It is possible that two separate sets of numbers will have to be maintained, with only the covered entities required to get one, while

others can elect to get one. Considering that entities can start filing applications this May (May, 2005), it is surprising that more isn't known. As information becomes available, it will be passed on.

Status of TEDS Reporting

The 2002 TEDS report was the first since TEDS reporting began in 1990 to include admission data from all the States, DC, and Puerto Rico. Moreover, as of the first of October, approximately 88 percent of the 2003 admission data had been submitted. Some 2003 data have been received from all but two States.

Currently Synectics uses four reports to monitor the frequency and quality of TEDS reporting.

1. A processing report is generated each time an admission or discharge submission is received from a State. This report shows the number of records processed and any errors found, and it forms the basis of the decision to accept or reject the records.
2. The monthly processing report summarizes the month's activity and is sent to OAS.
3. On a quarterly basis, individual State reports are prepared, each one showing all the records received in the last three years from a particular State. These reports are Synectics' primary method of checking the quality of the data submitted. Each quarter, a report is sent to each State.
4. If the State report shows a significant problem, Synectics sends a problem report to the State requesting clarification and possible correction.

Synectics is now tracking the match rate between admissions and discharges. Staff expects the match rate for discharges submitted to Synectics to approach 100 percent since all clients should, eventually, be discharged in some manner (the only exception being some methadone clients who may remain in treatment indefinitely). Currently, 94 percent of the discharges submitted have a matching admission record. From the reverse perspective, approximately 64 percent of the admission records have a matching discharge. Another general yardstick Synectics uses to evaluate reporting quality is to compare the number of discharges and admissions for a given time period. It expects that within a given year the number of admission records and discharge records should be about the same. Synectics will contact States with large differences to investigate the problem.

Synectics also continues to track admission submissions. If a State falls behind, the chances are good that Synectics' Mayra Walker will call the State representative to find out the reason for the delay.

SAMHSA's goal is to have all the data from a State for one calendar year by the end of the following year. Therefore, the goal this year is to have all the 2004 data in by December 31, 2005. Meeting this time schedule enables the TEDS annual report to be produced in a reasonably timely manner.

Selected Findings from TEDS Data

Leigh Henderson, Synectics, reported on the TEDS discharge data for 2002.

Twenty-five States reported discharge data in 2002. Data from 23 States were used for this analysis. The objective of the study was to examine treatment completion and length of stay (LOS) within service types (outpatient, intensive outpatient, short-term residential, long-term residential, and hospital residential). From each of these services detox and methadone clients were excluded and examined separately.

Shorter-term treatment services had higher completion rates, and there was little difference between treatment completion for different primary substances or by age.

For LOS, the median seems to be a better measure than the average. The average LOS is always longer than the median, indicating a long tail in the distribution. The median is less influenced than the average by extreme LOS due to clients having administrative closures often 60 or 90 days after last contact.

For each type of service, treatment completion rates and LOS were examined for socio-demographic, substance use, prior treatment, and treatment referral source variables. LOS was generally not associated with any of the variables, but treatment completion was associated with some of the variables in different service types.

Median LOS varied from 92 days for outpatient completers, which includes both "treatment completed" and "transferred to another substance abuse treatment program or facility," to 4 days for detox. Long-term residential was 71 days, intensive outpatient 52 days, short-term residential 25 days, and methadone 20 days.

Among clients in outpatient treatment, the rate of completion was the highest for White clients (46 percent), next Hispanic clients (38 percent), and then Blacks (33 percent). Completion rates by substance varied from a high of 50 percent for alcohol to 26 percent for opiates.

One of the more significant findings was the relationship between frequency of substance use at admission and completion rates. The rates dropped as frequency of use increased: while almost one half of clients reporting no use at admission were completers, 27 percent of those reporting daily use were completers.

Examining rates by source of referral, the rates were highest for clients referred by the criminal justice system or employers. Somewhat surprising was the low rate of completion for self/individual referrals (36 percent). As might be expected, the highest completers by employment status were those employed either full- or part-time.

During the presentation there was a discussion about the lag time between the reporting of an event to the State (admission or discharge) and the same event being reported to Synectics, and what would be a reasonable goal for States to meet. No definitive answer was given. The lag time between States varies considerably but is most affected by a system change. Most States fall well behind in their submissions during a transition period.

There also was a discussion of discharge date and date of last contact. Because of the use of administrative discharges (usually 60 or 90 days after last contact) for cases that never get a formal discharge, the date of last contact is considered superior for calculating length of stay.

State Presentations

District of Columbia

The District is close to implementing a new automated patient management system that is HIPAA compliant and utilizes web-based technology to eliminate redundant data entry and to electronically process patient billing.

The Softscape Case One client management system is scaleable, built on latest technologies, and yields high return on investment. The system will provide streamlined processing of new patients and patient tracking, cost of services tracking, voucher tracking, and electronic patient billing. It will help to manage methadone treatment and provide real-time statistical data and trend analysis.

The system has a web interface and is compliant with District IT standards. Reports will be developed using Crystal Reports. It is expected the DC government will save 2.5 million dollars over the next 3 years. The system is accessible from any location with Internet access. The data are secure and HIPAA compliant.

Florida

In July 2004, Florida implemented a web-based data collection system. The system was developed as a result of a State initiative and has served most data collection needs very well. However, the use of a multipurpose record for substance abuse reporting has proved to be a problem. During the planning stage and the subsequent small-scale testing, producing TEDS data appeared feasible. However, when the system went full time, there were problems. The system generates service events records and identifying a treatment episode with an admission and discharge has proven to be difficult. In addition, admission records can only be prepared when a client completes treatment. At this time, staff has worked out a system that will produce the necessary TEDS data, and, since the admission record is generated at the same time as the discharge record, there will be a 100 percent match between the admission record and the discharge record.

Florida is going to revise its data system again soon. The system will continue to be web-based. Staff is in the process of evaluating software for the new system, and WITS is a viable alternative. The new system will need to be operational by July 2007.

North Carolina

The Division of Facility Services licenses all substance abuse providers in North Carolina. In the past, the substance abuse agency has not had a complete file of substance abuse agencies and their locations, so a project was initiated to document the location of each individual provider. With the cooperation of the Division of Facility Services, the project began in July, and all the facilities had to be enrolled by September 30. The project included all service providers who provide services to Division of Mental Health, Developmental Disabilities and Substance Abuse Services clients. Now the billing of services can be connected to a provider at a specific location.

This system also enables the State to comply with I-SATS requirements. The location address has been geo-coded to support mapping and other geographic analysis. In addition, the Department of the Secretary of State lists all profit and non-profit substance abuse agencies. They are also available on a website.

This system will help to track two new performance measures that have been introduced for FY05:

1. Ninety percent of open clients who are enrolled in a target population and receive a billable service will have a completed identifying record and a completed demographic record in the Consumer Data Warehouse (CDW) within 30 days of the beginning date of the service on the paid claims record.
2. Ninety percent of open clients who are enrolled in a target population and receive a billable service must have a completed drug of choice record in CDW within 60 days of the beginning date of the service on the paid claims record.

South Carolina

South Carolina has a long history of collecting substance abuse data. It began in 1977 with data collected on a mainframe. In 1985, computerization at the provider level began, and by 1997 all providers had an electronic client management system. In 1998, South Carolina began collecting discharge data and, in 2001, outcome data. By 2003, providers had moved to a single client management system. The State is now moving to the enterprise version of the same system used by the providers.

The new system will allow for transaction-level editing at data entry, at the time of data submission, and after State review. There will be secure Internet transfer of data and data reports. This system and its accompanying checks will greatly improve data quality.

Incorporation of this software at the State level will reduce the work involved in producing reports at both the State and local levels. Future improvements include integrating an electronic clinical record into the reporting system and improving the coordination for dual diagnosis care between the substance abuse agencies and the Department of Mental Health.

At the present time, providers have submitted test data, a website host has been chosen, installation and site setup has begun, and conversion of pre-FY05 data has started.

The State produces reports on outcome measures, contract objectives, governor's goals, and performance measures. The measures to be used to evaluate performance are still being developed. The providers provide input on the performance measures. The State is searching for benchmarks that indicate good performance.

Virginia

The Virginia substance abuse data collection system is a decentralized system with 40 Community Service Boards (CSBs) and 15 State-operated facilities. The central office does not directly operate the CSBs. The 40 CSBs use eight different MIS systems to report client data.

In 1992, Virginia started a Statewide Client Automated Data System (SCADS) with an expanded version of the TEDS data system, including outcome measures. Since then, Virginia has participated in three outcome studies. From 1996 to 2003 the system was revised and was called the State Performance Outcome Measurement System (POMS). From 1998 to 2002, the State participated in the Treatment Outcomes and Performance Pilot Studies II (TOPSII). In 2004, the system was again revised and is now called the Community Consumer Submission (CCS). Data are submitted electronically on a monthly basis. The system uses a unique identifier which is a hashed social security number. The system is based on the TEDS mandatory data elements.

A comparison of some of the outcome reporting values shows a wide spread between POMS, SCADS, and CCS. POMS reported a higher rate of success in all measures. The percentage reductions in use of alcohol and other drugs were close between SCADS and CCS but differed greatly from POMS.

Virginia has collected discharge data since 1997. In the past, discharges were underreported. However, the gap is closing, and in 2003 the number of discharges equaled the number of admissions. Data about diagnosis, employment, pregnancy, education, and legal information is collected at time of admission and discharge.

Considerable effort is now going into data management and quality improvement. A full-time position is devoted to managing the data. This position is supported by the State Data Infrastructure Grant.

Several reports are sent to the CSBs, including two performance indicator reports and four quality control reports.

State and Sub-State Estimates from the National Survey on Drug Use and Health (NSDUH)

The target sample size for the NSDUH is 67,500 respondents annually. The sample is designed to provide State and some sub-State estimates. The overall response rate for the 2002–03 NSDUH was 71 percent. This ranges by age of respondent. Response rates for youths were the highest at 90 percent. The response rate for respondents 18–25 was 84 percent, and for respondents 26 and above 75 percent.

Subject to sample size limitations, direct estimates can be made at the national level for subgroups such as race, pregnant women, and for grouping of ages. Estimates can also be made for States or metropolitan areas, but generally only for large States or metro areas, or by combining several years of data.

For a selected set of outcome measures, State estimates are made using a model-based method. The survey uses a technique called Hierarchical Bayes Estimates. These estimates are a weighted estimate made by combining direct estimates for the State with an estimate for a sub-State-based national regression model.

An evaluation of model-based versus direct estimates found that model-based estimates were more precise than direct estimates, but they are limited to certain pre-selected measures. Direct estimates may have a large sampling error but can be done for any variable and subgroup that

has a sufficient sample size. Sufficient sample size usually requires combining more than one year of data.

OAS, working with CSAT and the States, has determined sub-State regions that are meaningful to the States. OAS will produce model-based estimates comparable to the ones produced for the States. They will be based on three years of data, from 1999, 2000, and 2001. Because of design changes in 2002, 2002 data cannot be combined with 2001 and earlier data. The sub-State areas require a minimum sample of 275. Preliminary sub-State areas were shown for the States attending the meeting.

Based on feedback from the States on the initial effort, OAS will revise the sub-State areas if needed and produce a second set of estimates based on 2002 to 2004 data.

National Outcome Monitoring System (NOMS) and Its Impact on TEDS

SAMHSA is in the process of developing outcome measures for substance abuse treatment, prevention, and mental health treatment. Two principles are applied in developing these measures: one is that all domains will have the same labels and measure the same things wherever possible, and the other is that the domain will cover events from the beginning of treatment to the end of treatment. These measures are important because SAMHSA needs to measure improvements in outcomes to justify treatment money and to identify areas that need improvement.

Ten domains have been formulated, as shown below. The measures for the first six domains are client-based data elements, and the measures for the last four are system-based data elements.

Client-based data elements	1. Abstinence
	2. Education/Employment
	3. Crime and criminal justice
	4. Family and living conditions
	5. Access (to care)
	6. Retention (in treatment)
System-based data elements	7. Social connectedness
	8. Perception of care
	9. Cost effectiveness
	10. Use of evidence-based practices

The first domain is abstinence. Data on this are currently collected in TEDS at admission. The expectation is that treatment will increase the number of clients who are abstinent at discharge or at least reduce their use of drugs.

Education and employment data are also currently collected by TEDS at admission. Expectations for these indicators is improvement in the number employed or retained in employment or in school.

An item on crime and criminal justice will be added to TEDS for collection at admission and discharge. The measure is a reduction or no change in the number of arrests in the last 30 days from the date of first service to the date of last service.

Next is family and living conditions. The measure is an increase or at least no change in the number of clients in stable living arrangements.

For retention in treatment, the expectation is an increase in the number of clients who stay in treatment.

Access to services is the sixth client-based domain. The measure requires that States have a system that will provide unduplicated client counts. The measure will be the penetration rate, that is, the unduplicated count of clients served compared with the number in need.

For cost effectiveness, the measure will be the number of States providing services within approved cost per person bands by type of treatment as established by CSAT. The data element will not be added to TEDS.

Under development are measures for social connectedness and use of evidence-based practices. At this point, the use of evidence-based practices is more clear in prevention than in treatment.

The impact of using TEDS as the main client-based system for client outcome measures could be considerable. Eventually, States will be expected to report many of the items in the current Supplemental Data Set, and selected admission variables will be collected again at time of discharge (primary, secondary and tertiary substances and frequency of use, employment status, living arrangement, detailed not in labor force).

Also, old issues are being re-examined. For example, who should be included in the system? All clients or only public clients? All providers or only those receiving public funds? How should an episode of treatment be defined? What should be done about the variation in State systems in their use of admissions and transfers when a client changes services or providers? A big issue for some States will be the development of a unique ID so an unduplicated count of clients can be obtained. All of these issues are still under discussion. Any or all can have a significant impact on a State system.

What are the benefits for the States? First, meeting the requirements will result in a more timely and comprehensive State system that will help States manage treatment more effectively, and second, an additional $150,000 payment will be added to the current DASIS payment.

This program will be phased in over three years, and SAMHSA's goal is to have all States able to report all TEDS data in a timely way and under high quality standards by September 2007.

SAMHSA expects as many as 30 States will be eligible in Year 1. It is estimated that another 16 States will become eligible for payment in Year 2, and by Year 3 all the States will be able to report to NOMS. There will be some technical assistance from SAMHSA to help some States in their system development.

To be eligible for payment, the States will have to submit a proposal demonstrating that they can report the required data and that it will meet certain quality standards. The requirements are still under discussion but one scheme being discussed is for States to report at least three of the domains at admission and discharge in Year 1, and to report all six of the client-level domains at admission and discharge in Year 2. States entering for the first time in the second year will have to come in fully ready to submit six domains since they will have had technical assistance.

SAMHSA's expectation is that the reporting schedule will be monthly and the lag time between admission or discharge event and reporting to TEDS will be within 6 months of the end of the quarter in which the event occurred for Year 1 and within 3 months of the end of the quarter in which the event occurred in Year 2. In terms of data quality, the expectation in Year 1 is that at least 95 percent of all admission elements must be reported accurately for old data elements and 80 percent for new elements. In Year 2, the standard will go up to 95 percent for all TEDS data elements. There will have to be a match rate between admission and discharge records of at least 90 percent. In addition, the TEDS crosswalks must be maintained and kept current, and rejected records and erroneous data will need to be corrected within 60 days.

Unlike the current DASIS payment, the proposed system will be a purchase of data, and the data will have to meet the timeliness and quality standards.

At this point States were asked for comments. Several issues were raised, including the need for definitions for some of the items and the need for sufficient time to meet the new criteria. States need final resolution of the remaining issues by SAMHSA as soon as possible, so States can prepare.

Leigh Henderson cautioned that the timeliness standard may prove to be a disincentive for completeness. States receiving records from a provider late may be reluctant to report them because they exceed the timely reporting criterion.

Charlene urged the States to continue to think about this program and its impact and send comments to OAS so that the program will be reasonable. Once the details of this program have been worked out, SAMHSA will make an announcement. OAS will keep States informed as further details emerge.

Closing Remarks

Charlene thanked all the participants for their input during the meeting and expressed her appreciation for the work State participants did in developing and making their presentations. Once again the interaction was most useful to OAS and DASIS staff.

DASIS REGIONAL MEETING

District of Columbia, Florida, Georgia, North Carolina, South Carolina, Virginia
March 22–23, 2005

Atlanta, GA

Tuesday

8:15 a.m. Continental Breakfast

8:45 a.m. Welcome and Introductions *Charlene Lewis, OAS*

9:00 a.m. National Survey of Substance Abuse Treatment Services (N-SSATS)..... *Geri Mooney, MPR*
- 2005 survey milestones..... *Barbara Rogers, MPR*
- Internet access and responding via the Web
- Plans for redesign of 2006 survey
- Discussion of proposed new questions for 2006

10:30 a.m. BREAK

10:45 a.m. Inventory of Substance Abuse Treatment Services (I-SATS) *Alicia McCoy, Synectics*
- Importance of I-SATS updates .....*Jim Delozier, Synectics*
- Approved vs. non-approved facilities and process for review .....*Deborah Trunzo, OAS*
- National Provider Identifier

11:15 a.m. Treatment Episode Data Set (TEDS).....*Leigh Henderson, Synectics*
- The status of Discharge Data Set and *s* monitoring discharge submissions .....*Jim Delozier, Synectic*
- Recent findings from TEDS

12:30 p.m. LUNCH

1:15 p.m. State Presentations ..... *State participants - DC, FL, GA*

2:45 p.m. BREAK

3:00 p.m. State Presentations - continued.....*State participants - NC, SC, VA*

4:30 p.m. Adjourn

Wednesday

8:15 a.m. Continental Breakfast

8:45 a.m. Sub-state Estimates from the NSDUH..... *Doug Wright, OAS*

9:45 a.m. BREAK

10:00 a.m. National Outcomes Measures and the Role of DASIS..... *Charlene Lewis, OAS*

11:00 a.m. Wrap-up

11:30 a.m. Adjourn

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Atlanta, Georgia
March 22 & 23, 2005

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